Ethics briefings

GMC reviews

In late 2005, the General Medical Council (GMC) carried out several consultations. In the review of procedures for sick doctors were proposals to strengthen powers to monitor doctors and plans to introduce unannounced drug testing of doctors whose behaviour raised concerns.[1] The GMC consultation on the strategic options for undergraduate medical education considered how education is changing in the light of social and clinical demands. It focused, in part, on developing guidance on medical students' health and conduct and a proposed national registration system for medical students.[2] The most significant consultation in terms of medical ethics was the GMC's review of Good Medical Practice – its main ethical guidance for doctors.[3] The GMC's aim was to re-define practical and attainable modern standards. A proposed draft emphasised partnership in the doctor-patient relationship, human rights, and doctors' obligations and responsibilities towards children—all of which are issues increasingly significant in medicine. The consultation also opened up discussion on how far the GMC should be concerned about doctors' behaviour in their private lives. Should it be concerned, for example, about clinically successful consultants being obsessed with hardcore pornography or having affairs with very young women?[4] Questions were also posed about how far doctors can exercise a conscientious objection. Should they be able to refuse to refer pregnant women for abortions because they themselves consider it wrong?[5] Other potentially contentious issues questioned the extent to which doctors have rights to protect themselves against risks from patients. British Medical Association (BMA) policy, dating from the era when HIV first began to be diagnosed, stated that it is unethical to withhold treatment solely because a patient's condition poses risks to doctors' health. At the time it was adopted, this policy was intended to be anti-discriminatory as HIV patients were already stigmatised. Doctors treating such patients, however, could take some precautions and some prophylaxsis is available. It remains open for discussion as to whether nowadays individual doctors have duties to deliberately expose themselves to new potentially lethal and highly infectious conditions for which there is no treatment or vaccine, particularly airborne infections, for example, SARS or the effects of biological weapons.[6] The revised Good Medical Practice is due for publication in autumn 2006.

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End of life – update

Doctors' conscientious objections also figured in the latest version of Lord Joffe's Assisted Dying for the Terminally Ill Bill, tabled in the Lords in November 2005.[7] As in previous Bills, doctors are said to have no duty to participate in diagnosis, treatment or other actions covered by the draft Bill. In addition, they have no duty to raise the option of assisted dying with a patient nor to refer patients on if they themselves have a conscientious objection. Health care facilities can prohibit assisted dying on their premises.[8] If the Bill ever becomes law, the onus will rest with individuals seeking assisted dying to locate a doctor and establishment willing to provide it.

Anxiety about the enforceability of any draft conscientious objection clauses had previously been raised at the BMA's annual meeting in June 2005. Speakers alleged that there had been discrepancies in the past between the conscience clauses allowed to doctors in law and the more restrictive clauses of their employment contracts. This is an issue which the BMA will be monitoring if the law changes and it started collecting relevant evidence. One study[9] of hospice workers in Oregon where assisted dying is legal, also highlighted discrepancies between legislation and practice. It found that while many of the staff opposed assisted dying, their sense of loyalty to their patients who requested lethal prescriptions meant that they continued to care for them and opposed them being discharged from hospices. Many helped patients come to a decision but were uncomfortable about such discussions. This highlighted that legal exemptions alone can be insufficient in practice where staff already feel they have a duty of care and alternative counsellors and advisers need to be at hand.

The same study also highlighted the difficulty inherent in attempts to isolate assisted suicide from hospice and palliative care. ''Clinically it fails because assisted suicide involves much more than procuring and administering lethal drugs. It involves a complex process in which patients seek information about many aspects of dying, including assisted suicide, with a trusted relationship with hospice professionals.''[9] When assisted suicide is legal, questions about it inevitably arise and all health professionals, including hospice staff receive such queries and need to have methods of dealing with them. They highlighted the need for further research about how health professionals' personal views influence their responses to patients and what kinds of support and education would be needed to ensure that communication was effective.

Continued challenge to oregon law

In October 2005, the US Supreme Court, presided over by new Chief Justice John Roberts, started considering the apparent clash between federal law and Oregon's assisted suicide law.[10] The Bush administration has long sought to annul Oregon's Death with Dignity Act. Although Oregon remains the only US state to permit doctors to prescribe a lethal dose for terminally ill patients, other states are poised to consider similar legislation.

From the start, legal challenges delayed the implementation of the Oregon law, passed in 1994 and it continues to face legal obstacles. In 2002, former Attorney General John Ashcroft tried to annul it, arguing that it violated federal drug laws and represented an improper use of medication by doctors. The ''Ashcroft Directive'' declared that using drugs in assisted suicide violated the Federal Government's Controlled Substances Act (CSA). Ashcroft ruled that the CSA and the Oregon Law were in conflict but the Ashcroft Directive was overruled by an appeals court, which said that it was unclear that the Attorney General had the power to decide the legitimacy of a medical purpose under the CSA. In the case called *Gonzales* v *Oregon*, a group of Oregon residents, including a doctor, pharmacist, and terminally ill patients challenged the subsequent Attorney General, Alberto Gonzales, on the interpretation of the clash between the CSA and the Oregon law. This interpretation

is now before the supreme court. At its heart is a question about the degree to which individual US states can rule their own affairs and how much they must abide by decisions taken centrally. As a Catholic and a conservative, John Roberts was expected to oppose assisted dying but he also traditionally supported the right of States to decide important issues for themselves without federal government interference. In the opening court session, however, he repeatedly raised concerns that Oregon rules on assisted dying could undermine the effectiveness of federal regulation of addictive drugs. The outcome of the current Supreme Court hearings should clarify whether the Oregon law is compatible with the US constitution and so is likely to affect whether other States attempt to follow it.

Judicial review

In November 2005, a judicial review of the Department of Health's 2004 guidance – Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual, and reproductive health – commenced in the High Court. Sue Axon, a mother of two teenage girls, sought a judicial review of the guidance, which states that young women under 16 can have a termination of pregnancy without the consent or knowledge of their parents. Mrs Axon argued that a parent's right to know should override the duty of confidentiality. The outcome is awaited at time of writing.

Changes to World Medical Association declarations

In 2004–5, there was international media coverage of the alleged involvement of health personnel in interrogation of detainees in Guantánamo Bay.[11] This was said to have included the sharing of detainees' health information with interrogators and the designing of interrogation techniques to exploit their physical and psychological weaknesses. Subsequently, the US Defence Department published guidance on the role of health personnel in interrogation, saying that doctors not employed in a direct therapeutic capacity were not bound by conventional medical ethical standards.[12] This contravened accepted international codes of practice, including World Medical Association (WMA) Declarations.[13] The WMA, therefore, set up a working group, including the BMA, to clarify further the Declarations of Tokyo and Geneva and its Regulations in Times of Armed Conflict. Its aim is to prohibit such conduct unambiguously. Changes to the WMA Declarations should be discussed at the WMA's meeting in May 2006.

Force-feeding of detainees in Guantánamo Bay

In October 2005, concerns about breaches of codes of medical ethics in Guantanámo Bay intensified after Amnesty International issued an urgent action request in relation to medical complicity in the force-feeding of detainees.[14] Hunger-striking detainees were said to be restrained by soldiers while members of the medical staff inserted wide-bore naso-gastric tubes. Such tubes were also said to be brutally inserted and removed by members of the Immediate Reaction Force in doctors' presence. The forcible feeding of hunger striking prisoners by physicians is contrary to internationally agreed standards of medical ethics. The BMA points out that when brutally done, forced feeding can amount to torture and advises doctors that when competent and informed prisoners refuse nourishment, they should not be fed artificially.[15]

References

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